Financial Management Standards/ Accounts Receivable and Reimbursement Procedures For Community Services Boards

Virginia Department of Mental Health, Mental Retardation and Substance Abuse Services

Volume III

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SECTION

.100 INTRODUCTION

The Introduction portion of the manual is intended to provide an overview of the Reimbursement portion of the Financial Management Policies and Accounting Procedures Manual.

The manual is intended to be structured in a manner that will provide guidance in all phases of the Reimbursement function. It is written in a manner that is consistent with and gives consideration to other DMHMRSAS Policy, Commonwealth of Virginia statutes relative to CSB fee collections and Reimbursement activities, Federal requirements that impact all phases of fee collections including Medicare and Medicaid regulations, third party insurance requirements, generally accepted accounting principles and DMHMRSAS directives.

This manual provides guidance with practical application of Medicare and Medicaid Regulations. However, this manual is not intended as a replacement for any policy document produced by the carriers or intermediaries responsible for these programs.

It is intended that the CSB system will structure the Reimbursement functions of each Board and program within their control in a manner consistent with the information provided in this manual. The staff of the DMHMRSAS will provide assistance to Boards in the Boards' efforts to achieve compliance with these instructions.

The DMHMRSAS will ensure compliance with the standards and procedures contained in this manual by application of the Financial Management and Accounting (Reimbursement) Evaluation Module, review of audit reports and recommendations for corrective actions.

Each section of this manual is written consistent with existing Reimbursement regulations and policies. The applicable policies are contained in specific sections but are not necessarily repeated for all sections.

.100 INTRODUCTION

CSBs are managed by an Executive Director who is responsible for administration and clinical service delivery.

Reimbursement is part of the administrative function of a CSB. Each CSB should have a Reimbursement Officer whose main responsibility is to maximize the CSB's client and third party reimbursement, and see that the Code of Virginia is followed as it relates to CSB reimbursement.

In order that revenues may be maximized, the Reimbursement Officer should have responsibility over CSB employees who perform functions related to reimbursement. Such employees may perform financial interviews, collections, client and third party billing, and ability to pay determinations. The reimbursement systems that are generally most efficient and effective tend to be centralized in their organizational structure.

.200 RESPONSIBILITY AND AUTHORITY FOR REIMBURSEMENT

.210 Code of Virginia, § 37.1-197(7). Community services boards; local government department; powers and duties.

"Every operating community services board or local government department with a policy-advisory board shall:

7. Prescribe a reasonable schedule of fees for services provided by personnel or facilities under the jurisdiction or supervision of the board and establish procedures for the collection of the same. All fees collected shall be included in the performance contract submitted to the local governing body or bodies pursuant to § 37.1-197(2) and § 37.1-198 and shall be used only for community mental health, mental retardation and substance abuse purposes. Every operating board and local government department with a policy-advisory board shall institute a reimbursement system to maximize the collection of fees from persons receiving services under their jurisdiction or supervision consistent with the provisions of § 37,1-202.1 and from responsible third party payors. Operating boards and local government departments with policy-advisory boards shall not attempt to bill or collect fees for time spent participating in involuntary commitment hearings pursuant to § 37.1-67.3."

.220 § 37.1-202.1 Liability for expenses of services.

"The income and estate of a consumer shall be liable for the expenses of services under the jurisdiction or supervision of any operating community services board, administrative policy board, or local government department with a policy-advisory board that are utilized by the consumer. Any person or persons responsible for holding, managing or controlling the income and estate of the consumer shall apply such income and estate toward the expenses of the services utilized by the consumer.

Any person or persons responsible for the support of a consumer pursuant to § 20-61 or a common law duty to support shall be liable for the expenses of services under the jurisdiction or supervision of any operating community services board, administrative policy board, or local government department with a policy-advisory board that are utilized by the consumer unless the consumer, regardless or age, qualifies for and is receiving aid under a federal or state program of assistance to the blind or disabled. Any such person or persons responsible for support of a consumer pursuant to § 20-61 or a common law duty to support shall no longer be financially liable, however, when a cumulative total of 1,826 days of (i) care and treatment or training for consumer in a state mental health facility or training center; or (ii) the utilization by the consumer of services under the jurisdiction or supervision of any operating community services board, administrative policy board or local government department with a policy-advisory board; (iii) a combination of (i) and (ii) has passed, and payment for or a written agreement to pay the assessment for 1,826 days of care and services has been made. Not less than three hours of service per day shall be required to include one day in the cumulative total of 1,826 days of utilization of services under the jurisdiction or supervision of any operating community services board, administrative policy board, or local government department with a policy-advisory board. In order to claim this exemption, the person or persons legally liable for the consumer shall produce evidence sufficient to prove eligibility therefor."

.300 REIMBURSEMENT POLICY

.310 DMHMRSAS Board Policy #86-14

Renewed 3/23/88
Updated 2/28/90
Updated 4/28/93

POLICY MANUAL

State Mental Health, Mental Retardation and Substance Abuse Services Board
Department of Mental Health, Mental Retardation and Substance Abuse Services

POLICY 6002(FIN)86-14 Services Availability and Ability of Client to Pay Philosophy

Authority
Board Minutes Dated October 22, 1986
Effective Date November 19, 1986
Approved by Board Chairman s/James C. Windsor

References
Section 37.1-197, Subsection 7, and 37.1-202.1, Code of Virginia (1950) as amended.

Background
Community services boards (CSBs) are agencies of local government, established to provide service to the mentally ill, mentally retarded, and substance dependent residents of their localities. The referenced statutes establish and define liability for the cost of services and require boards to institute reimbursement systems to maximize the collection of fees for services. It is apparent from the foregoing that community programs are not established to serve only indigent clients. However, as a public provider of services, community services boards give special consideration to individuals who do not have the ability to pay the full cost of these services. Service delivery programs are funded through multiple sources. A significant area of funding is fee collection. All recipients of services are charged and expected to pay for the services they receive to the extent of their individual financial ability. While emphasis on fee collection is appropriate, this emphasis must not result in restrictions of services to individuals who do not have the ability to pay.

Purpose
To establish the State Board's position regarding the availability of services to individuals who are not able to pay the full cost of such services.

Policy
It is the policy of the State Mental Health, Mental Retardation and Substance Abuse Services Board that all clients be afforded services based on their identified needs and within available resources. These services cannot be denied to individuals who do not have the ability to pay.

Each community service board must have reimbursement policies and procedures that specifically address ability to pay. The form of ability determination is at the discretion of each Board. No client will be denied services due solely to financial considerations; however, it is essential that CSBs differentiate between those clients who are actually unable to pay (even the fees based on ability to pay) and those clients who possess the necessary resources but choose delinquency rather than the payment of a reasonable charge for services rendered.

Ability to Pay processes involve first charging the client for the services provided and then reducing the original charge based on established policy at the CSB. Such a policy should base discounts of charges on household income and routine household expenses. It is important that all clients be treated in a consistent manner.

Delinquent accounts are those accounts which have been reviewed under a CSB's Ability to Pay policy and it has been determined that the client does have the financial resources to make payments, *but* the client chooses not to do so.

It is further the policy of the Board that the Department of Mental Health, Mental Retardation and Substance Abuse Services assist the community services boards with the development of ability-to-pay policies. The

Department shall provide guidance, oversight and consultation to facilitate greater consistency across the CSB system in the development of criteria for determining ability to pay.

The Commissioner shall assign a staff coordinator who will develop a plan for implementation, monitoring and evaluation of this policy.

.400 SAMPLE REIMBURSEMENT POLICIES AND PROCEDURES – SEE APPENDIX-B

.500 SAMPLE REIMBURSEMENT OFFICER JOB DESCRIPTION – SEE APPENDIX-C

.600 SAMPLE REIMBURSEMENT SPECIALIST JOB DESCRIPTION – SEE APPENDIX-D

.100 INTRODUCTION

Abuse is defined as any practice that is inconsistent with accepted sound fiscal, business or professional practice which results in a claim, unnecessary cost, or payment for services or supplies that are:

1) not within the concepts of medically necessary and appropriate care, or
2) that fail to meet professionally recognized standards for health care providers.

The term "abuse" includes deception or misrepresentation by a provider or any person or entity acting on behalf of a provider in relation to a claim. Fraud is defined as (1) deception or misrepresentation by a provider, beneficiary, or any person acting on behalf of a provider or beneficiary with the knowledge (or who had reason to know or should have known) that the deception or misrepresentation could result in some unauthorized benefit to self or some other person, or some unauthorized payment, or (2) a claim that is false or fictitious, or includes or is supported by any written statement which asserts a material fact which is false or fictitious, or includes or is supported by any written statement that (a) omits a material fact and (b) is false or fictitious as a result of such omission and (c) is a statement in which the person making, presenting, or submitting such statement has a duty to include such material fact.

.200 ANTI FRAUD AND ABUSE LAWS

Fraud in the United States' health care system is a serious problem that has an impact on all health care payers and affects every person in this country. There are several anti-fraud and abuse laws that affect the healthcare industry. They include, but are not limited to the False Claims Act, Whistle Blowers Act and the Health Insurance Portability and Accountability Act (HIPAA).

.210 FALSE CLAIMS ACT

The False Claims Act was amended in 1986 to improve the Government's ability to recover false or fraudulent payments. Now the Act imposes treble damages liability and civil penalties of $5,000 - $10,000 per claim plus three times the amount of the claim on any person who knowingly presents, or causes to be presented, a false or fraudulent claim for approval to the U.S. Government. It prohibits the submission of a false or fraudulent claim and/or making a false statement or representation in connection with a claim. The Act is the primary means of recovering

damages for losses to the Medicare Trust Fund (and other government sponsored programs). It is also the primary means of recovering fraudulently claimed dollars from health care providers, including hospitals. To prove liability, the Government must show actual knowledge of falsity, reckless disregard for truth or falsity, or deliberate ignorance of truth or falsity. "Deliberate ignorance" reaches those who consciously ignore or fail to inquire about readily discoverable facts that would alert them that a given claim is false. Billing errors due to simple negligence, mistakes, or inadvertence are actionable under the False Claims Act. The government must prove at a minimum a "deliberate ignorance" or a "reckless disregard" of the truth or falsity of the claims submitted by the provider.

.220 WHISTLE BLOWERS ACT

Whistle Blower's Act – The "Qui Tam" provisions of the False Claims Act, referred to as the "Whistle Blower's Act", was also amended in 1986 and provides for the incentive for whistle blowers to overcome the substantial detriment and obstacles to speaking out. Often, a whistle blower is a health care employee with inside knowledge of wrongdoing. When he/she blows the whistle, he/she invariably becomes an outcast in the industry. However, the qui tam provisions allow such whistle blowers to act as private attorneys general and bring suit under the False Claims Act seeking recoveries against defrauders of government programs. The whistle blower may share in any recoveries by the federal government of those providers found to have committed fraud.

.230 POSTAL FRAUD

Postal Fraud – The U. S. Postal Inspection Service is the law enforcement branch of the U.S. Postal Service, empowered by federal laws and regulations to investigate and enforce federal statutes related to crimes against the U.S. Mail, the Postal Service and its employees. Postal inspectors investigate any crime in which the U.S. Mail is used to further a scheme, whether it originated in the mail, by telephone or on the Internet. The use of the U.S. Mail is what makes it a mail fraud issue.

.240 HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)

Health Insurance Portability and Accountability Act (HIPAA) – In 1996 Congress and the President authorized the Fraud and Abuse Control Program under the Health Insurance Portability and Accountability Act.

The program is designed to provide a framework and resources to coordinate Federal, State, and local law enforcement efforts. It mandates a comprehensive program of investigations, audits, and evaluations of health care delivery; authorizes new criminal, civil and administrative remedies; requires guidance to the health care industry about potentially fraudulent health care practices; and establishes a national data bank to receive and report final adverse actions imposed against health care providers.

.300 REPORTING FRAUD AND ABUSE

Each agency has procedures for reporting fraud and abuse. Consult the individual carrier's provider manual for specific information on how to report fraud and abuse.

Department of Medical Assistance Services
Trailblazers
TRICARE
Anthem Blue Cross Blue Shield
U.S. Postal Service
Centers for Medicare & Medicaid (CMS)

.100 ACCOUNTS RECEIVABLE - GENERAL

The Accounts Receivable or Reimbursement activity of a CSB is an integral part of that Board. The Reimbursement activity is required by the Code of Virginia, § 37.1-197(7). Reimbursement is also an essential element of the total funding required by the Board for programs for its citizens.

The elements of an effective accounts receivable system are:

1. establishing charges for services rendered;
2. collection of accurate client data;
3. billing clients or third-party insurers for delivery of such services;
4. collection of monies as payment for such services; and
5. providing reports of these activities to monitor the progress of the accounts receivable system.

The ultimate goal of the accounts receivable process is the recovery of the cost of providing the various services to the clients.

The State Board Policy that is part of the reimbursement system for public providers is the **Ability to Pay** policy, whereby the provider must determine what the client is able to pay towards the cost of his/her service. The adjustment of such accounts is also a part of the accounts receivable system.

It is the responsibility of Board management to analyze the components of the accounts receivable system for potential weaknesses, and review the reports on a regular basis to assess the effectiveness of the current system.

.200 COST ACCOUNTING AND RATE SETTING

The most prevalent method businesses use for setting a charge for the goods or services is by relating the charge to the cost of providing those goods or services. CSBs should set their rates at the cost of providing the service in order to help offset their overall cost of operations.

.210 COST ACCOUNTING DEFINED

Cost accounting is the process an organization uses to determine the full cost of providing a unit of goods or services. In the process of cost accounting, the direct costs of providing the product such as salaries and materials are considered; however, indirect costs such as administration, payroll, and utilities are allocated to each unit of goods or

services provided. Through this method of cost allocation, the true cost of providing one unit of goods or service can be determined. When used as a tool to set charge rates, the full cost of a product can be recovered.

.220 RATE SETTING DEFINED

Rate setting can be defined as the process by which an organization sets a charge rate it feels is fair and reasonable for its goods or services. These charge rates are set based on the financial requirements of the organization, and are used to cover the cost of providing the goods or services. For-profit organizations also take into account a profit component and a return on shareholders' investments.

.230 COST ACCOUNTING PROCESS FOR CSBs

CSBs are required to submit annual budgets and performance contracts to DMHMRSAS prior to the beginning of their fiscal year. These reports require the CSB to provide information on types of services offered by the CSB, along with projected units of service and direct costs of that service. In addition, administrative costs are required to be allocated to each disability area. Using this information, the unit cost of each service can be determined.

For example, consider a CSB's mental health emergency services area. This area employs 5 FTE's, with total salary expenses of $100,000, and total non-salary expenses of $20,000. The estimated units of service for the budgeted fiscal year are 3,000. Additionally, the total amount of administrative expenses allocated as overhead to the mental health division for the budget year is $85,000, and the mental health division employs a total of 40 FTE's. Below is the calculation for the unit cost for mental health emergency services.

DIRECT COST -

Direct expenses-	
Salary	$100,000
Non-salary	20,000
Total direct	$120,000
Total direct	$120,000
Units of service	3,000 = $40 direct cost per unit
Indirect Expenses -	
Adm. O/H	$ 85,000

Total FTE's	40 = $2,125 per FTE
Cost/FTE	$ 2,125
Program FTE's	x 5
Program O/H	$ 10,625
Program O/H	$ 10,625
Units of service	3,000 = $ 3.54 indirect cost per unit

Total Unit Cost -

Direct cost per unit	$ 40.00
Indirect cost per unit	3.54
Total cost per unit	$ 43.54

The total cost per unit of mental health emergency services is $43.54 in this example. To allow for inflation through the year and unanticipated expenditures, a fair charge for one unit of emergency services would be $45.

This same procedure should be followed for each type of service provided by the CSB, whether or not a fee is charged for the service.

Additional information may be obtained from the DMHMRSAS' CSB Financial Management Standards and Accounting Procedures manual.

.240 ALLOWABLE VS. NON-ALLOWABLE COSTS

It is important to realize that not all costs are allowed by all payers, particularly as they relate to Medicare and Medicaid. Only costs that are directly related to the care and maintenance of clients are generally allowed, with overhead for administration of the program, maintenance of the physical plant, and depreciation of related fixed assets.

.250 COST REPORTING

ICF/MRs require a cost report to be submitted on an annual basis after fiscal year end. This report must be submitted within 90 days from the close of the fiscal year.

While some information and schedules are program-specific, the basic information is similar for all cost reports. The following information is necessary for all reports:

1. Census days or visits;
2. Total FTE's for the program;
3. Salary and non-salary expenses, by department or contractual provider;
4. Itemized expenses in the non-salary administration expense category;
5. Adjustment of non-allowable expenses from the affected categories;
6. A schedule to summarize and accrue remittances for the year;
7. A schedule summarizing total expenses, total charges, total payments, and a total amount due to the intermediary or to the provider.

Instructions for completing the reports are included in the manuals furnished by the intermediary.

.300 RECONCILIATIONS

.310 REVENUES

Revenues must be balanced on a daily basis. This process would include verifying that all service tickets issued to clinical staff are returned to the reimbursement office for proper posting to the client's account.

Each service ticket should have an appropriate charge for the service rendered. At the end of the business day, the charges for services rendered should be totaled, and should reconcile to the amount of charges posted to all client accounts for the day.

Over the counter cash receipts and mail receipts must be reconciled as prescribed in the Financial Management Standards and Accounting Procedures manual for CSBs.

.320 SERVICES

Services should be balanced at least on a weekly basis, if possible.

The service indicated on the tickets should be checked against those listed on any available reports.

.400 INTERNAL CONTROLS

Internal control consists of the plan of organization and the methods and measures to:

1. safeguard assets
2. check accuracy and reliability of accounting data
3. promote operational efficiency
4. encourage adherence to prescribed managerial policies

A system of strong internal controls can minimize a CSB's exposure to:

1. fraud, abuse, and waste
2. budget deficits
3. non-compliance with Board policies and procedures
4. inaccurate financial reporting
5. public scrutiny due to financial improprieties

The Executive Director has the ultimate responsibility for the system of internal controls. The Fiscal Director shall be tasked with implementing the system of internal controls.

There are nine standards of internal control. They are:

1. Documentation – Internal controls should be documented.
2. Recording – Transactions should be recorded as executed and should be classified properly.
3. Authorization – Transactions should be executed as authorized.
4. Structure – Key duties should be separated so that no one person controls all phases of an activity.
5. Supervision – Supervisors should ensure that procedures are followed.
6. Security – Access to assets is limited to authorized personnel.
7. Competent Personnel – Key personnel should be competent and have high standards of integrity and demonstrated experience that will enable them to perform accounting functions.
8. Reasonable Assurance – Internal controls provide reasonable, but not absolute assurances that control objectives will be accomplished.
9. Records – Records should be secure from unauthorized use.

There are three basic tools to use when documenting and analyzing internal control strengths and weaknesses: flowcharting, narratives, internal control questionnaire.

1. Flowcharting is a graphic presentation of the major processes involved in an operation.
2. Narratives are written descriptions of the major processes involved in an operation.
3. An Internal Control Questionnaire is a document used to assess the adequacy of controls relating to operations. The questionnaire is structured to make assessments of the nine standards of internal control.

.100 GENERAL STATEMENT OF POLICY

Each community service board must have reimbursement policies and procedures that specifically address ability to pay. The form of ability determination is at the discretion of each Board. No client will be denied services due solely to financial considerations; however, it is essential that CSBs differentiate between those clients who are actually unable to pay (even the fees based on ability to pay) and those clients who possess the necessary resources but choose delinquency rather than the payment of a reasonable charge for services rendered.

Ability to Pay processes involve first charging the client for the services provided and then reducing the original charge based on established policy at the CSB. Such a policy should base discounts of charges on household income and routine household expenses. It is important that all clients be treated in a consistent manner.

.200 FINANCIAL INTAKE

The registration of clients is when the collection process is initiated. All pertinent client financial information should be obtained during the financial intake interview. Information considered pertinent includes, but is not limited to:

A. Client's full name
B. Client's social security number
C. Client's home address and telephone number
D. Client's employer's address and telephone number
E. Client's insurance information along with a copy of the insurance card
F. If the client is a minor, additional information should also include the parent's social security number
G. Income verification

This information should be updated on an annual basis or whenever changes to the client's financial situation occur.

.210 INTERVIEW TECHNIQUES

Financial interviews should be conducted at the initial client visit to the center whenever possible. In emergency situations, the interview should be conducted as early on in the therapy as possible, when the client is able to provide such information.

Financial interviews should always be held in a private office whenever possible and should also be completed in a professional manner to promote and assure client dignity.

Questions should be asked in such a manner as to encourage the client/responsible party give more than a "yes" or "no" answer, when possible. For example,

Ask - "Where do you work?", rather than "Do you work?"

Ask - "What insurance do you have?", rather than "Do you have insurance?" or "You don't have insurance, do you?"

There are also several forms that need to be signed during the intake process. These forms are listed below along with a brief description of each.

1. Assignment of Benefits Form - This allows payment from third-party carriers to be sent directly to the Community Services Board.

2. Release of Medical Information Form - This allows the Community Services Board to release medical information to third-parties when there is a question whether benefits will be payable for services rendered.

3. Financial / Payment Agreement - This allows the Community Services Board to pursue collections for five (5) years.

4. Freedom of Choice – This provides evidence that the CSB has given the client freedom of choice in seeking medical care from any other qualified provider, as well as, assure the client's freedom to reject medical care and treatment.

Clients have the right to make informed decisions regarding the services they receive and ultimately their payment responsibility. Therefore, it is recommended that clients be made aware of the fact their insurance will not cover specific providers and/or specific services. To protect the provider from liability, there needs to be evidence of the client's knowledge and advanced notification that specific providers and/or services are not covered. Therefore, a waiver of liability form should be signed by the client.

.300 FINANCIAL INTAKE FORM (SAMPLE)

CSB FINANCIAL INTAKE FORM

Client Account #: _____

[ ] New - Date:_____
[ ] Update – Date: _____

***Client Information*:**
Client Name:_____
Client Address: _____
_____
Employer: _____

Social Security # : _____
Date of Birth #: _____
Home Telephone #: _____
Work Telephone #: _____

Responsible Party Information:
Responsible Party Name: _____
Address: _____
_____
Employer: _____

Social Security #: _____
Home Telephone #: _____
Work Telephone #: _____
Relationship To Client: _____

***Spouse / Parent Information:* [ ] Spouse [ ] Parent**
Name: _____
Address: _____
_____
Employer: _____

Social Security #: _____
Home Telephone #: _____
Work Telephone #: _____

Insurance Information:
Medicaid #: _____
[ ] Primary [ ] Secondary [ ] Tertiary Coverage
Medicaid Waiver Patient Pay Amount: $_____

Effective Date: _____
[ ] QMB Only [ ] QMB Extended [ ] Not Applicable
Effective Date: _____

Medicare #: _____
[ ] Primary [ ] Secondary [ ] Tertiary Coverage

Effective Date: _____

Commercial Insurance
Insurance Co. Name: _____
[ ] Primary [ ] Secondary [ ] Tertiary Coverage
Policy #: _____
Insurance Co. Address: _____
_____

Effective Date: _____
Policy Holder Name: _____
Group #: _____
Insur. Co. Telephone #: _____
Pre-Authorization Required: [ ] Yes [ ] No

Insurance Co. Name: _____
[ ] Primary [ ] Secondary [ ] Tertiary Coverage
Policy #: _____
Insurance Co. Address: _____
_____

Effective Date: _____
Policy Holder Name: _____
Group #: _____
Insur. Co. Telephone #: _____
Pre-Authorization Required: [ ] Yes [ ] No

Income Information:
Total Gross Monthly Household Income:$_____
Number of Family Members in the Household: _____

Total Gross Annual Household Income: $_____

I certify that the above information is true and accurate. I agree to notify the CSB immediately of any changes in this information that may occur during the course of treatment.

_____ _____
Client Signature/Responsible Party Date

CSB Staff Name: _____ Date of Next Financial Review: _____

Attachments Required: [ ] Income Verification [ ] Income Worksheet [ ] Copy (Front & Back) of ALL Insurance Cards

.310 Advance Beneficiary Notice -SEE APPENDIX A

.320 WAIVER OF LIABILITY FORM
(SAMPLE- ONLY)
(Payment Options Should Be Based on Board Policy)

Client Name: _____ Account #: _____

[ ] _____ Initials I am aware I will be receiving services from a provider that my insurance company has defined as not being a reimbursable provider. I understand these services cannot be billed to my insurance company. I agree to pay at the time of service an amount which is determined by the Board's ability-to-pay mechanism.

[ ] _____ Initials I am aware I will be receiving services from a provider that my insurance company has defined as not being a reimbursable provider. I understand these services cannot be billed to my insurance company. As a result, the CSB will not charge me for the services not covered by my insurance company when rendered by this provider: _____(Provider Name)

[ ] _____ Initials I am aware I will be receiving services from an intern and that my insurance company has defined him/her as not being a reimbursable provider. I understand these services cannot be billed to my insurance company. As a result, the CSB will not charge me for the services not covered by my insurance company when rendered by an intern.

[ ] _____ Initials I wish to be placed on a waiting list until a provider defined as being reimbursable becomes available.

[ ] _____ Initials I wish to seek services from another provider who my insurance company has defined as being reimbursable provider.

[ ] _____ Initials I am aware I will be receiving services that are not covered by my insurance company. I agree to pay at the time of service an amount which is determined by the Board's ability-to-pay mechanism. (List services or attach list)

_____
_____

I have been notified of the possibility that my insurance company will deny payment for services identified above, for the reasons stated. I agree to being responsible for payment as indicated above.

_____ _____
Client Signature Date

_____ _____
Witness' Signature Date

.400 FEE ASSESSMENT METHODOLOGY

At the initial financial intake, the intake/reimbursement clerk should complete the questionnaire as completely as possible. To determine the fee that will be assessed, only two items from the questionnaire should be considered:

1. household income; and
2. number of family members in the household.

Household income is defined by the family unit. It is made up of all the people dependent on the same income. This would include parents, minor children, full time students (if the support is coming from the parents), handicapped children (not able to provide for their own support), or other minor children that is in legal guardianship of parents. A child that is of a majority and is no longer a student or handicapped is a separate family unit. An emancipated child is a separate family unit. A handicapped child that receives SSDI, SSI or other funds as a result of their disability is a separate family unit. A parent or other person of majority residing in the home is a separate family unit even if they have
no income at the present time.

The questionnaire should be completed for all clients regardless of third-party coverage. If the client has coverage, the fee assessment will not apply to any ***covered*** service. The client will be responsible for any co-payments and/or deductibles as outlined on the explanation of benefits.

.410 INCOME/EMPLOYMENT VERIFICATION

Income should be verified on all clients. This will help ensure that clients receive the amount of assistance they actually need and only clients in need of assistance actually qualify. Verification can be in the form of several recent paycheck stubs, tax forms, W-2 forms, copies of assistance program or retirement checks. Additionally, in accordance with § 60.2-114 (C) and § 60.2-623(B) client employment and wage information can be obtained online through the Virginia Employment Commission for a nominal fee. Online access can be obtained by contacting:

Manager of Customer Service
Virginia Employment Commission
Post Office Box 1358
Richmond, Virginia 23211
(804) 786-4359

.420 CLINICIAN INVOLVEMENT

The clinician is an important component of the ability to pay process. Using their relationship with the client, they can assist with making the client pay the assessed amount, determining changes in clients' financial status, and assisting the client with an appeal. The clinician should emphasize that payment is a part of the client's responsibility, and is a part of his/her therapy. The clinician should take a small part of the session
to discuss past due balances, circumstances that may be affecting payment, and positive or negative changes in the client's financial status. This information shall be relayed to the reimbursement office.

.500 FINANCIAL RECORDS

Client financial records shall be complete and updated at least annually and maintained in a lockable file cabinet free from unauthorized use, alteration or destruction. The financial record should contain the following:

1. Financial questionnaire/intake
2. Signed assignment of benefits and release of information form(s)
3. Income verification
4. Signed payment agreement
5. Copies of third party payer cards
6. Third-party verification
7. Collection letters, if applicable
8. Other related correspondence

Maintaining accurate financial records leads to a more effective reimbursement or accounts receivable system that provides for a realistic financial assessment and has a positive impact on collection of fee revenue.

.600 PAYMENT

Payment should be collected at the time service is rendered. A client who requests new and/or additional services and has a previous "open" account which has become delinquent, should be requested to pay the "open" balance in full prior to receiving any new and/or additional services. The only exception should be with those clients who present in crisis. Ideally, clients should pay at the time of service. If this is not possible, suitable payment arrangements should be made. Payments should be scheduled at least monthly, and a payment notice or bill should be sent. Prompt contact should be made with the client if a payment is missed.

While installment payments are not encouraged for paying client balances, they are at times unavoidable. When installment payments must be used, the reimbursement office should take the initiative to offer a payment plan that will settle the account in the shortest time possible. All installment payment agreements should be in writing and signed by the client. The agreement should outline the terms for payment and inform the client of the consequences should he/she become delinquent (i.e., debt set-off).

.700 APPEAL PROCESS

If a client appeals his/her fee assessment, a more in-depth review of the financial questionnaire should be performed. Allowances should be made for the following monthly expenditures (this is not an all inclusive list):

1. housing (main residence);
2. utilities (gas, water, electricity, trash);
3. basic telephone (no long distance or special functions);
4. reasonable food;
5. medical bills; and
6. transportation

After these expenses are deducted from the household income, the client should be placed on the fee scale and a new assessment should be completed.

All appeals should be approved by the Fiscal Administrator or his/her designee. In cases where an appeal is requested for clinical reasons, input from the Clinical Director should be obtained.

.800 MINIMUM FEES

All CSBs should set a reasonable minimum fee that will produce revenue and be cost-effective. While circumstances of hardship should be considered on an exception basis, a reasonable minimum fee of $5 per visit is recommended.

.100 INTRODUCTION

Collections play an integral part in the Community Services Board - client relationship. From the initial intake interview, through the time the client ceases using the board's services, the fee collection process is involved. In accordance with the Code of Virginia, § 37.1-197(7), the Board shall establish a reimbursement system to maximize the collection of fees from persons receiving services. The CSB is obligated to collect the cost of services from third party sources and from those who have the ability to pay. No individual can be denied services due to **inability** to pay and all clients must be charged in a like manner regardless of financial ability or third party coverage. Acceptance of payment less than full fee should require the client to undergo an in depth financial intake. The involvement of clinicians/therapist/case managers in the collection process will further assist the CSB with maximizing revenue.

.200 ACCOUNT FOLLOW-UP

.210 BILLING

The first step in the collection process is getting the claim in the hands of the responsible payer as soon as possible. Claims will be submitted at least monthly to the responsible payer.

.220 PROGRAM ACCOUNTS (MEDICARE, MEDICAID, ETC.) AND INSURANCE ACCOUNTS

1. Submit claim within 30 days of date of service;

2. Follow-up with Carrier 30 days after claim is submitted;

3. Follow-up with Carrier in 5 day increments until claim is resolved;

4. Program and insurance accounts should be resolved within 60 days of the original billing;

5. Should a balance remain after the program/insurance has paid its portion, follow self-pay policy.

.230 SELF-PAY ACCOUNTS - ACTIVE CLIENTS

1. A statement is mailed to the client or responsible party within a 30 day billing cycle.

2. Follow-up with client or responsible party 30 days after original billing with a past due notice. Additionally, inform the client's clinician/therapist/case manager of the past due amount.

3. Follow-up with client or responsible party 60 days after original billing with a delinquency letter. Again, inform the client's clinician/therapist/case manager of the delinquency. The clinician/therapist/case manager should discuss this delinquency with the client and inform him/her that if payment is not received, services could be terminated.

4. Follow-up with client or responsible party 90 days after original billing with a face-to-face contact. Any necessary arrangements should be made at this time in an attempt to get the account paid. Inform the clinician/therapist/case manager of the outcome of the meeting.

5. If settlement has not been reached within 120 days of original billing, the account is referred to the Clinical Director/Executive Director for consideration of termination of services due to **refusal** to pay and/or submission to Debt Set-Off. This specific step should be outlined in detail in the reimbursement policy and procedures manual and approved by the Board of Directors.

.240 SELF-PAY ACCOUNTS - CLOSED CASES

1. An itemized statement is mailed to the client or responsible party within 30 days of date of service.
2. Follow-up with the client or responsible party 30 days after original billing with a past due notice.
3. Follow-up with the client or responsible party 60 days after original billing with a delinquency letter and a telephone call.
4. Follow-up with the client or responsible party 90 days after original billing with a letter of final notice indicating the account will be turned over for collection if payment is not received in 10 days.

5. If settlement has not been reached within 100 days of the original billing, the account is removed from the active Accounts Receivable and placed with Debt Set-Off or any private collection agency.

.300 WRITE-OFF OF UNCOLLECTIBLE DEBT

Managing the accounts receivable requires consistent follow up on outstanding accounts and subsequent write-off of uncollectible debt. Accounts should be written off accounting records when all collection procedures have been conducted without result and the account is deemed uncollectible. Industry standards state that accounts not paid in full when services are rendered are less likely to be collected the older the account becomes. The CSB should establish written policies and procedures that determine which accounts will be written off. The policy should include the following:

1. Debt Set-Off or collection agency
2. Adjudicated bankruptcy
3. Deceased
4. Small balance
5. Age of accounts selected for write-off

.400 BANKRUPTCY

Bankruptcy law is a federal statutory law contained in the U.S. Code, Title 11. Bankruptcy proceedings are supervised by and litigated in the United States Bankruptcy Courts. States do not regulate Bankruptcy, however, they may pass laws that govern other aspects of the debtor-creditor relationship.

There are two basic types of Bankruptcy proceedings, Chapter 7 and Chapter 13. The most common is filing under Chapter 7, which is generally referred to as liquidation. Liquidation involves the appointment of a trustee who collects all non-exempt property from the debtor. Exempt property may include family bible, wedding rings, burial plots, automobiles, basic household items, and work-related tools. The trustee may sell the property collected and distribute the proceeds to the various creditors. Or, the trustee could turn over the property to the creditors. The debtor will then receive a discharge of any unpaid debts claimed under Chapter 7. A discharge is a court order that says they do not have to repay certain debts to those creditors listed under Chapter 7. If the debtor failed to list a creditor under Chapter 7, the discharge does not apply to the unlisted creditor.

Chapter 13 allows the debtor to use future income to pay off their debts and keep their assets. The Bankruptcy Court will approve a three to five year repayment plan. After the debtor has made all of the payments under the plan, he/she will receive a discharge of any unpaid debts to listed creditors claimed under Chapter 13. If the debtor failed to list a creditor under Chapter 7, the discharge does not apply to the unlisted creditor.

The Bankruptcy Code also establishes the priority in which creditors are repaid. First, in line for repayment is the secured creditor. A secured creditor is one that has a lien against a particular piece of property. The sale of this property must be used to satisfy the debt to this creditor before it is used to satisfy debts to other creditors. Second in line for payment are the priority creditors. Congress has granted priority to debts owed to the Federal Government, i.e.: the Internal Revenue Service. The last in line for payment are all other creditors.

Once the Bankruptcy petition has been filed and the Board has been notified as being a listed creditor, all means of collection, including Debt Set-Off, must be stopped immediately. Collection efforts cannot be resumed for any amounts owed prior to the date the bankruptcy petition was filed. Furthermore, any amounts matched or received under the Debt Set-Off program after the date the Bankruptcy petition was filed or 90 days prior to the date of filing, must be released or returned. Since Community Service Boards are the last in line to receive payment, it is recommended any charges incurred prior to the date of the Bankruptcy petition be written off as bad debt. Collection efforts may continue for charges incurred after the date the Bankruptcy petition was filed. These charges are not covered under the Bankruptcy petition. In addition, collection efforts may continue for all charges incurred if the debtor failed to list the Community Services Board as a creditor.

.500 STATUTE OF LIMITATIONS

The Code of Virginia, § 37.1-202.1, concerns the liability for expenses of services provided by Community Services Boards. The code states a limit of- 1,826 days of service for which a client or family can be held liable. There is also a formula given to convert partial days of service into full days. While this code section does not specifically state a time limit for collection of the debt, there are other civil statutes that must be considered.

In the civil statutes, § 8.01-246 (2) & (4) are to be applied to the collection of debts owed to Community Services Boards.

§ 8.01-246 (2) & (4), Civil Statute - Personal Actions Based on Contracts

"Subject to the provisions of § 8.01-243 regarding injuries to person and property and of § 8.01-245 regarding the application of limitations to fiduciaries, and their bonds, actions founded upon a contract, other than actions on a judgment of decree, shall be brought within the following number of years next after the cause of action shall have accrued:

(2) In actions on any contract which is not otherwise specified and which is in writing and signed by the party to be charged thereby, or by his agent, within five years whether such writing be under seal or not;

(4) In actions upon any unwritten contract, expressed or implied, within three years."

The basic rule is that a written contract, or a signed fee agreement, can be enforced up to five years from the date of service while an unwritten contract, such as may occur in emergency situations, can be enforced up to three years from the date of service. This applies to accounts sent to Debt Set-Off, as well as other collection methods.

.600 AGED ACCOUNTS RECEIVABLE TRIAL BALANCE

Accounts receivable trial balance is a tool used in the collection process. It is essential to act on delinquent accounts before they become rather than reacting when a debt is realized as uncollectible. Accounts receivables should be aged on a regular basis. Aging of accounts helps collection follow up since it identifies at a glance which payors or individuals need attention in addition to regular statements. The aging is generally divided into 30, 60, 90 and over 120 days old by payor (for example, self pay, Medicaid, Medicare, etc.). The aging report is simply a tool to show at a glance the status of each payor. The outstanding receivables for each payor should be analyzed and further collection activity invoked.

.100 THIRD PARTY PAYORS GENERALLY

Third party payors are companies or agencies who pay for the services provided to subscribers. This includes commercial insurance companies such as Trigon BCBS, Aetna, Cigna, etc. and any HMO's.

Billing third party payors for services rendered is a courtesy provided to clients, however, the client is ultimately responsible for payment.

.200 MEDICAID

Medicaid was established in 1969 as a part of the Social Security Act under Title XIX and is administered by the Department of Health and Human Services.

In Virginia, the Department of Medical Assistance Services (DMAS) under the direction of the Secretary of Health and Human Resources has the responsibility to administer Medicaid services under the State plan. The DMAS has contracted with the Department of Social Services (DSS) for the determination of financial eligibility for medical assistance and the provision of related social services.

Medicaid, an assistance program, is for certain needy and low income people; i.e., the aged, (65 or older), the blind, the disabled, members of families with dependent children and some other children. Medicaid is a federal-state partnership. Money from federal, state, and local taxes pays medical bills for eligible people. Medicaid can pay what Medicare does not pay for people who are eligible for both programs.

For further information, refer to the following manuals:

Medicaid Mental Health Clinic Manual
Medicaid Community Mental Health Rehabilitation Services
Medicaid Mental Retardation Community Services
Medicaid Rehabilitation Manual
Medicaid Nursing Home Manual (ICFMR)
Medicaid Medallion

These manuals can be accessed at the Department of Medical Assistance Services' website:
http://www.cns.state.va.us/dmas/

.300 MEDICARE

Medicare (officially known as Title XVIII of the Social Security Act-Health Insurance for the aged and disabled) is a federal health program for individuals 65 years of age or older and certain disabled individuals. It is run by the Centers for Medicare & Medicaid of the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services.

Medicare is, in fact, two separate and distinct programs. The two programs differ with respect to type of benefits, method of financing, nature of participation by beneficiaries, and the legal basis for their operation. These two programs are generally designated by sections of the Title XVIII from which they originate - Part A and Part B.

The fiscal intermediary for the Medicare program is TrailBlazer. Further information may be obtained at the following website: **http://trailblazerhealth.com/**

.400 ANTHEM BLUE CROSS BLUE SHIELD

Trigon Blue Cross Blue Shield issues a provider number for each category of provider to the community services boards. Those categories are: Physician, Certified Nurse Specialist, Speech Therapist, Physical Therapist, Licensed Clinical Social Worker, and Licensed Professional Counselor.

A provider agreement must be completed by the community services board in order to become a participating provider.

Coverage may vary according to the subscriber's contract. Call the Provider Inquiry Unit at the number below to check benefits.

Richmond	804/342-0010
Other areas	800/533-1120

For contracts that have psychiatric benefits managed, care must be authorized before services are rendered. Further information may be obtained at the following website: **www.anthem.com**

.500 TRICARE (Formerly CHAMPUS)

The TRICARE program was formerly known as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS). TRICARE is the name of the health care program for the DoD (Department of Defense). TRICARE is a network of military and civilian hospitals, clinics, and medical professionals. It offers a wide range of health care benefits and guarantees timely access to care. The health care delivery network is contracted by the DoD to manage the TRICARE Mid-Atlantic and TRICARE Heartland regions. TRICARE, as its name implies, gives beneficiaries three options for care: TRICARE Prime, TRICARE Extra and TRICARE Standard. TRICARE Standard is the TRICARE basic benefit program and remains the same as Standard CHAMPUS.

All individuals entitled to military health care who are under the age of 65 are eligible for participation in TRICARE. Certain Medicare eligibles over age 65 may also be entitled to TRICARE benefits. This includes active duty military personnel and family members, and retired service members and their family members and survivors. All eligible for military health benefits.

Persons not eligible for TRICARE include: Medicare eligible beneficiaries (except active duty family members and others as defined by TRICARE), CHAMPVA beneficiaries, and Active Duty Personnel or eligible beneficiaries currently enrolled with United States Treatment Facility. Further information may be obtained at the following website: **http://www.tricare.osd.mil/**

.510 CHAMP/VA (Civilian Health and Medical Program of the Veterans Administration)

CHAMP/VA is a health benefit program for the families of veterans with 100% service-connected disability and the surviving spouse or children of a veteran who dies from a service-connected disability. Once eligibility has been established, benefits are cost-shared the same way that TRICARE covers families of retirees.

.520 DEERS (Defense Enrollment Eligibility Reporting System)

In order to have TRICARE claims processed and to receive non-emergency care in service hospitals, TRICARE eligible military personnel and their families must be enrolled in DEERS. DEERS is a worldwide database of military families, retirees and others covered by TRICARE. Enrollment in DEERS is required of both active and retired military sponsors and all family members.

.600 OTHER THIRD PARTY PAYORS AND HEALTH MAINTENANCE ORGANIZATIONS (HMO)

All other third party payors and / or health maintenance organizations (HMOs) should be handled as follows:

1. Have the client sign an Authorization for Release of Medical Information and an Assignment of Benefits form.

2. Verify coverage during the client's initial intake making sure that the clinician providing the service is a reimbursable provider.

3. It is important to determine if services must be pre-authorized. Obtain pre-authorization / certification if required. Failure to do so could cause denial of payment. Pre-authorization may also be necessary when a primary care physician refers a client for services.

4. Many third party payors and / or health maintenance organizations (HMOs) require claim forms be filed with the carrier within 30 days after the date of service.

5. It is important the CSB becomes familiar and thoroughly understands the requirements outlined in the provider participation agreement, as well as, any provider manuals that are issued by the third party payor and / or health maintenance organizations (HMOs). Being knowledgeable of the third party payor and / or HMO specific billing requirements will avoid unnecessary claim denials.

.100 INTRODUCTION

The Social Security Administration's (SSA) Representative Payee Program providers fiduciary assistance to beneficiaries who are incapable of managing or directing someone else to manage their Social Security or SSI payments. The SSA generally looks for family or friends to serve in this capacity. When family or friends are not able to serve as payee, SSA looks for qualified organizations to be a representative. Once a representative payee is appointed, the beneficiaries benefits are then paid in the representative payee's name on the beneficiary's behalf. (See the Representative Payee section of the Social Security Handbook which can be found at http://www.ssa.gov/).

.200 DUTIES AND RESPONSIBILITIES

A representative payee must keep informed about the beneficiary's needs so that decisions can be made on how benefits can best be used for personal care and well being. Any money left after meeting the beneficiary's current and reasonably foreseeable needs must be saved and maintained in the beneficiary's behalf. Periodically, Social Security will ask the representative payee to complete a form accounting for the funds received.

The representative payee must keep Social Security informed of changes that may affect the beneficiary's eligibility for benefits. They are required by law to use benefits properly. If a payee misuses benefits, he or she must repay the misused funds to the beneficiary. A payee convicted of misuse may be fined and/or imprisoned.

The payee must first make sure the beneficiary's day-to-day needs for food and shelter are met. Then benefits may be used for the beneficiary's personal needs, such as clothing, recreation and other expenses. Benefits also can be used to pay for medical needs and dental care not provided by Medicare, Medicaid or a residential institution.

.300 RECORD KEEPING

The representative payee must keep records showing how much was received in benefits and how the money was used. These records must be kept for two years from the time a Representative Payee Report was completed. A payee is required to account for the funds received by completing this form.

.400 REPORTING CHANGES

The representative payee must notify Social Security about any changes that may affect the checks received. The payee is liable for repayment of money received on behalf of the beneficiary if any of the events listed below occur and are not reported.

- The beneficiary dies;
- The beneficiary moves;
- The beneficiary starts or stops working, no mater how small the amount of earnings is;
- A disabled person's condition improves;
- The beneficiary starts receiving another government benefit, or the amount of the benefit changes;
- The beneficiary will be outside of the U.S. for 30 days or more;
- The beneficiary is imprisoned for a crime that carries a sentence of over one month;
- The beneficiary is committed to an institution by court order for a crime committed because of a mental impairment.;
- Custody of a child changes or a child is adopted;
- The beneficiary is a stepchild, and the parents divorce;
- The beneficiary gets married;
- The payee is no longer responsible for the beneficiary; or
- The beneficiary no longer needs a payee

.500 INSTITUTIONS SERVING AS PAYEE(S)

Institutions that serve as representative payee sometimes places funds for several beneficiaries in a single checking or savings account. This is called a collective account. This is usually acceptable, but special rules apply to these accounts. Contact Social Security for more information.

.100 DESCRIPTION OF A.S.A.P. PROGRAMS

.200 REQUIRED SERVICES

.100 DESCRIPTION OF A.S.A.P. PROGRAMS

The Virginia Alcohol Safety Action Program (ASAP) is a systems approach to impact the drinking/driving problems in Virginia. This systems approach consists of the following countermeasures:

1. Enforcement
2. Judicial
3. Classification
4. Education/Treatment
5. Public Information/Education
6. Evaluation

ASAP is a statewide referral program. As an agency of the court system, ASAP only receives referrals from courts. To participate in ASAP, the defendant may petition the court. Motion is made by the defendant or his attorney after a plea of guilty to driving under the influence or after the court has found the defendant guilty as charged. Each defendant is assigned a case manager who will monitor program participation, assist with problem areas and report to the court. An assessment is made by the case manager to the extent of the client's problem and at this point the client will be referred to a community agency for treatment (i.e., CSB).

ASAP is a self-supporting system. The mandated fee is designed to cover the following:

1. Screening and Evaluation
2. Case Management Services
3. Program Administration
4. Education and Substance Abuse Treatment*
5. Public Information and Education

*Substance Abuse Treatment is very expensive and requires individual, group, and other therapeutic activities; therefore, the cost of this treatment is not fully covered by the ASAP fee. Each defendant assigned to treatment is expected to share the cost of the service. The cost will vary between agencies; however, every consideration is given to the cost to the defendant prior to referral. Health insurance covers cost of treatment in many cases.

.200 REQUIRED SERVICES

ASAP provides the following services to defendants referred to its program:

1. Screening and Evaluation
2. Case Management Services
3. Education and Substance Abuse Treatment

Defendants are referred to community programs for substance abuse treatment. Often ASAP has a contractual relationship with community agencies to provide this service.

.100 CIVIL COURT HEARINGS/EVALUATIONS

.200 CRIMINAL COURT HEARINGS/EVALUATIONS

.100 CIVIL COURT HEARINGS/EVALUATIONS

Anyone presumed to be mentally ill to the point which requires hospitalization may be admitted under voluntary or involuntary procedures. When possible, voluntary admission is preferred.

In accordance with § 37.1-67.01 any magistrate may, upon the sworn petition of any responsible person or upon his own motion, issue an emergency custody order (ECO) requiring any person within his judicial district who is incapable of volunteering or unwilling to volunteer for treatment to be taken into custody and transported to a convenient location to be evaluated by a person designated by the Community Services Board (CSB) who is skilled in the diagnosis and treatment of mental illness and who has completed a certification program approved by the DMHMRSAS in order to assess the need for hospitalization. The person shall remain in custody until a temporary detention order (TDO) is issued or the person is released, but in no event shall the period of custody exceed four hours. The prescreening that is performed by the CSB staff during the ECO is billable to the person and / or all third-party carriers, except for Medicaid. However, in accordance with § 37.1-89 no fees or costs shall be recovered from the person who is the subject of the examination or his estate when no good cause for his admission exists or when the recovery would create an undue financial hardship.

In accordance with § 37.1-67.1 a magistrate may, upon sworn petition of any responsible person or upon his own motion, and only after an in-person evaluation by an employee of the local CSB or its designee, issue a temporary detention order (TDO) if it appears from all evidence readily available that the person is mentally ill and in need of hospitalization and that the person presents an imminent danger to self or others, and the person is incapable of volunteering or unwilling to volunteer for treatment. A magistrate may issue a TDO without an ECO. An employee of the local CSB or its designee shall determine the facility of temporary detention for all individuals detained. The employee of the CSB or its designee who is conducting the evaluation shall determine, prior to the issuance of the TDO, the insurance status of the person. The duration of temporary detention shall not exceed forty-eight (48) hours prior to a hearing. Services provided to the person while under a TDO are billable to all third-party carriers, except for Medicaid. In accordance with § 37.1-67.4 if there is no third-party coverage, the Department of Medical Assistance Services will process claims for payment for both Medicaid eligible and non-Medicaid eligible persons. Please refer to the Medicaid Hospital Manual for specific billing instructions.

In accordance with § 37.1-67.3 the judge, in commencing the commitment hearing, shall inform the person whose involuntary admission is being sought of his right to apply for voluntary admission and treatment. If the person is incapable of accepting or unwilling to accept voluntary admission and treatment, the judge shall inform such person of his right to a commitment hearing and right to counsel. The commitment hearing shall be held within forty-eight (48) hours of the execution of the TDO. In accordance with § 37.1-197.7 the CSB shall not attempt to bill or collect fees for time spent participating in involuntary commitment hearings pursuant to § 37.1-67.3

Services provided to a person prior to the execution of an ECO and / or TDO and services rendered after the completion of the commitment hearing is billable to all third-party carriers, including Medicaid, and the person.

.200 CRIMINAL COURT HEARINGS/EVALUATIONS

The United State Supreme Court ruled that at any time before trial, if the court feels there is probable cause to believe the defendant's sanity will be a significant factor in his defense, the indigent criminal defendant is entitled to "psychiatric assistance" at the government's expense.

The assistance includes a clinical examination to evaluate the defendant's sanity, and where deemed necessary, to help in evaluating, preparing, and presenting a defense.

It is of the opinion of the Court that the indigent defendant is entitled to the kind of expert assistance he or she might expect from a personally retained psychiatrist or licensed clinical psychologist, while at the same time the defendant is not entitled to personally select a clinician of his or her choosing or to receive funds to employ such expert.

VIRGINIA CODE SECTION 19.2-175
Forensic Evaluation Fee Schedule
July 1, 1990

EVALUATION:

Competency to Stand Trial	$200
Mental Status at the Time of the Offense (MSO)	$300
-if competency evaluation previously conducted	$200
Mental Status at the time of the Offense and Competency to Stand Trial	$400
Pre-sentence Evaluation	$300
-if one pre-trial evaluation (competency or MSO) previously conducted	$200
Pre-sentence Evaluation (Capital Cases)	$400
-if one pre-trial evaluation (competency or MSO) previously conducted	(No limit on charges at Judges discretion)
Expert witness testimony	$100/per day

.100 INTRODUCTION

The Department of Mental Health Mental Retardation and Substance Abuse Services reimbursement staff performs two types of reviews of community reimbursement systems. First, in conjunction with the Commissioner's Evaluation/Review process as outlined in the performance contract, and secondly, in response to a request by an Executive Director. In both situations, the purpose of this review is to enhance the existing reimbursement function of the community services board.

The review process includes, but is not limited to:

1. A review of policies and procedures relative to the reimbursement function.
2. A sampling of client records.
3. A review of internal financial reports and internal controls.
4. Interviews with administrative, program and reimbursement staff.

All board reimbursement functions are measured against Generally Accepted Accounting Principals, the Code of Virginia and it pertains to CSB reimbursement operations, and other applicable state and federal regulations and third party requirements.

The objectives of the review includes but is not limited to:

1. Compliance of systems, policies and procedures and operations with appropriate regulatory standards.
2. Analysis of the reimbursement system for compliance with established board policy.
3. Fee revenue maximization.
4. Determination of the condition of the reimbursement operation, including appropriate internal controls.
5. Develop recommendations to enhance the effectiveness of the existing reimbursement system.

At the conclusion of the reimbursement review, the CSB shall submit a formal plan of correction to the Department within 30 days of receipt of the draft report. Minor compliance issues must be corrected within 30 days of submitting the plan. Action to correct major compliance issues must be initiated within 30 days and completed within 180 days of submitting the plan, unless the Department grants a written waiver. The results of the review and the CSB's progress in correcting any deficiencies may be included in any information about the boards that may be issued by the Department.

.200 INTERNAL CONTROL QUESTIONNAIRE – SEE APPENDIX E

A. MEDICARE ADVANCE BENEFICARY NOTICE FORM

B. SAMPLE REIMBURSEMENT POLICIES AND PROCEDURES

C. SAMPLE REIMBURSEMENT OFFICER JOB DESCRIPTION

D. SAMPLE REIMBURSEMENT SPECIALISTJOB DESCRIPTION

E. INTERNAL CONTROL QUESTIONNAIRE

Patient's Name: Medicare # (HICN):

ADVANCE BENEFICIARY NOTICE (ABN)

NOTE: You need to make a choice about receiving these health care items or services.

We expect that Medicare will not pay for the item(s) or service(s) that are described below. Medicare does not pay for all of your health care costs. Medicare only pays for covered items and services when Medicare rules are met. The fact that Medicare may not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case, **Medicare probably will not pay for –**

Items or Services:
Because:

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, knowing that you might have to pay for them yourself. Before you make a decision about your options, you should **read this entire notice carefully.**

- Ask us to explain, if you don't understand why Medicare probably won't pay.
- Ask us how much these items or services will cost you (**Estimated Cost: $**_____), in case you have to pay for them yourself or through other insurance.

PLEASE CHOOSE **ONE** OPTION. CHECK **ONE** BOX. **SIGN & DATE** YOUR CHOICE.

☐ **Option 1. YES. I want to receive these items or services.**

I understand that Medicare will not decide whether to pay unless I receive these items or services. Please submit my claim to Medicare. I understand that you may bill me for items or services and that I may have to pay the bill while Medicare is making its decision. If Medicare does pay, you will refund to me any payments I made to you that are due to me. If Medicare denies payment, I agree to be personally and fully responsible for payment. That is, I will pay personally, either out of pocket or through any other insurance that I have. I understand I can appeal Medicare's decision.

☐ **Option 2. NO. I have decided not to receive these items or services.**

I will not receive these items or services. I understand that you will not be able to submit a claim to Medicare and that I will not be able to appeal your opinion that Medicare won't pay.

Date **Signature of patient or person acting on patient's behalf**

NOTE: Your health information will be kept confidential. Any information that we collect about you on this form will be kept confidential in our offices. If a claim is submitted to Medicare, your health information on this form may be shared with Medicare. Your health information which Medicare sees will be kept confidential by Medicare.

OMB Approval No. 0938-0566 Form No. CMS-R-131-G (June 2002)

PURPOSE

To provide guidance for the establishment, assessment and collection of fees for services rendered to clients of the Community Services Board through its directly operated programs and contractual agencies and to assure that such fees are established in accordance with state statutes and regulations, in recognition of fiscal constraints, and in consideration of the needs of a client for services.

REIMBURSEMENT POLICY

1. It is the Community Services Board policy to serve all citizens in need of our services. It is our obligation to collect the cost of services from third party sources and from those who are able to pay.

2. Every effort shall be made to identify third party payers and clients shall be advised of this option. Failure by a client to utilize third party coverage, where applicable, shall result in assessment of full fee regardless of financial status.

3. No person shall be denied services due to inability to pay. Every effort shall be made to fairly set fees according to client's ability to pay.

4. Full fee shall be charged to all clients receiving services. Fee adjustments shall be determined by the Net Disposable Income as determined on the Financial Intake Form and based on this information clients are assigned an adjusted fee according to our fee scale. The Community Services shall absorb the difference between actual fee for services and amount determined as appropriate fee for clients.

5. Acceptance of less than full fee shall require the client or their guardian to undergo a financial intake, which will include providing proof of income. Proof of expenses may be required if they exceed allowable amounts.

6. In accordance with the Code of Virginia, 37.1-197 (7), we shall establish a reimbursement system to maximize the collection of fees from persons receiving services. Such a system shall take into account the need to provide services to persons regardless of their ability pay. Clinicians/Case Managers will play an active roll in collection procedures, when appropriate, by incorporating account delinquency situations into the client's treatment plan.

7. Reimbursement records will be kept on file for a minimum of 5 years.

8. The Financial Intake Questionnaire and multiple forms will be updated on a yearly basis. A minimum fee of $5.00 is charged. All fees are determined by information received through the financial intake process based on determination of their net disposable income. Payment for services rendered is expected at the time of each visit. Third party co-payments and deductible amounts will not be routinely waived. Clients will be responsible for payment of any and all "Non-Covered" services. Clients will be informed of the fee policy at the time of their financial intake.

9. All clients will be treated and charged in a like manner regardless of financial ability or third party coverage.

Approved_____ _____
Secretary Date

Adopted: January 1, 2001

REIMBURSEMENT PROCEDURES

I. INTRODUCTION

Clients are to be notified in advance of the information required for the financial intake.

A. Income verification

1. Current pay stubs
2. Copy of assistance checks
3. Copy of retirement checks
4. W-2 form
5. Current year tax return

B. When the appointment is scheduled, a search is to be conducted to determine if this is an established client and if there are any monies owed to the Community Services Board.

C. If the client is an established client owing money to the COMMUNITY SERVICES BOARD, he/she is to be informed of the amount of payment required prior to services being rendered. **EXCEPTION: THE CLIENT IS BEING SEEN FOR EMERGENCY SERVICES!**

II. FINANCIAL INTAKE

A. The client is informed of the reimbursement policy

1. The client is charged full fee for services rendered.
   The client may request a fee adjustment with appropriate income verification and every effort shall be made to fairly set fees according to client's ability to pay.
2. The client may use third party coverage to meet his/her obligation. However, if the client chooses not use his/her third party coverage they are not eligible for a fee adjustment.
3. Due to a federal mandate, there is not a routine waiver of co-insurance or deductible amount.
4. There is a minimum fee of $5.00.
5. Payment for services is expected at the time of each visit or according to the terms of their service agreement.
6. Client will be responsible for the payment of any "non-covered" services.
7. It is the client's responsibility to inform reimbursement staff immediately of any change in their financial status.

B. A Financial intake will be done on all clients requesting a fee adjustment.

C. Financial intakes will be performed in a private setting.

D. Financial intakes are performed at the time of the initial appointment.

E. A financial questionnaire must be completed.

F. Proof of income is required from the client or their guardian prior to any fee adjustment.

G. Proof of expenses exceeding the allowed amount will be required.

H. A signature from the client of responsible party is required certifying the information on the financial questionnaire is accurate.

III. DETERMINING CLIENT FEE

There are four approved fee categories for the:

(1) Full Fee Client

(2) Full Fee Payment Plan

(3) Insurance Client

(4) Financial Assistance

A. Full Fee Client/Full Fee Payment Plan
If the client does not request or qualify for a fee adjustment:

1. Complete and have the client or responsible party sign a "Financial Fee Agreement" form checking the appropriate box.

   a. Full Fee – Client agrees to pay full fee for services rendered at the time of the visit.

   b. Full Fee Payment Plan – Client agrees to pay full fee in monthly installments.

B. Fee Adjustment Client
Client requests and qualifies for an adjusted fee.

C. Insurance Client
Client has third party coverage to assist in payment of services and is not eligible for a fee adjustment.

1. Make a copy of the client's third party insurance card.
2. Have the client sign an "Authorization of Benefits" form.
3. Have the client sign a "Release of Information form".
4. Complete and have the client or responsible party sign a "Financial Fee Agreement" form checking the insurance box.

IV. FINANCIAL FOLDER

A. A client financial folder is created to include the following information/forms:

1. The client account number is automatically assigned by the computer.
2. Financial intake questionnaire.
3. Income verification.
4. Copy of third party insurance cards when applicable.
5. Signed "Financial Agreement" form.
6. Signed "Authorization of Benefits" form when applicable.
7. Signed "Release of Information" form when applicable.
8. Correspondence
9. Documentation of any telephone calls regarding account.

If client expresses hardship with his/her sliding fee, the "appeal" process may be performed. Upon completion and approval, the client must sign a revised Financial Agreement.

V. SERVICE TICKETS

A. After the initial financial intake has been completed or upon the client's arrival for further visits, a pre-numbered, two-part service ticket is created/completed for the client to include his/her name and account number.

B. One copy of the service ticket is detached and kept at the front desk.

C. The remaining copies are attached to the client's chart, given to the therapist and at the end of each session the therapist completes the service ticket. For those clients seen after hours, therapist is responsible for picking up tickets from the front desk before the close of the day and completing and returning them the following day.

D. Upon completion of the visit, the clinician is to verify all information printed on the ticket, correct any incorrect information and complete the service ticket with the following information:

1. Service rendered to the client.
2. The amount of time it took to render the service.
3. Clinician's signature.

E. The front desk staff will then do the following:

1. Match their copy of the service ticket with completed service ticket the client provides the.
2. Request payment from the client for services received.
3. If a check is received as payment it will be endorsed immediately.
4. Provide the client with a pre-numbered receipt for his/her payment.
5. All service tickets are then forwarded to the Reimbursement Office for batch entry/posting.

VI. RECEIPTS

A. Counter Receipts:

1. All checks will be endorsed immediately upon receipt and forwarded to the reimbursement office for processing and deposit.

2. Pre-numbered receipts will be issued for all payments made, regardless whether the client requests one or not.

3. Receipts received at satellite offices are proved and receipt numbers verified before forwarding to the Reimbursement Office with recap, copies of receipts, and signature of responsible party at that particular satellite office.

4. The A/P Fiscal Technician receives the receipts from the satellite offices, verifies receipt numbers and proves the receipts before forwarding to the Fiscal/Reimbursement Officer.

B. Receipts Received via Mail:

1. Payments received via mail are opened by the Administrative Assistant, or in his/her absence, by the Fiscal Technician.

2. All checks are endorsed immediately upon receipt.

3. All payments received via mail will be recorded in the Daily Mail Log Book.

C. The log and payments received via mail plus receipts received from the satellite offices are given to the Reimbursement Officer who will verify the deposit with the log and prepare the bank deposit.

1. Collections are reconciled with the receipt book when either of two criteria is met:
   (a) $100.00 has accumulated in the money box, or
   (b) One months receipts have accumulated.

2. Copies are made of all checks received.

3. Three copies are made of the bank deposit ticket. One copy is kept in the Reimbursement Office and attached to supporting documents i.e. copies of the checks, copies of the counter receipts and recap forms from the satellite offices. These documents are used for payment posting to client's accounts and then filed in the Monthly Fee Revenue Deposit File. The 3rd copy is filed in the Deposit Log Book and at the end of each month transferred to the Cash/Bank Statement Reconciliation Book.

4. The complete bank deposit is given to a staff member of the Fiscal Office or Administrative Assistant, who will then take the deposit to the bank.

5. The bank furnishes us with two copies of the Deposit Receipts. One copy is attached to the Reimbursement Office's copy and one is attached to the Fiscal Technician's copy.

VII. BILLING

Billing to ALL pay sources will be done monthly.

A. All services must be submitted for data entry by the 5th day of every month.

B. End-of-the month processing will be accomplished every month and will include the following:

1. Self pay monthly statements

2. Medicare claims

3. Medicaid claims

4. Blue Shield (UBS) claims

5. Commercial carrier claims

6. Substance Abuse contracts

7. Detailed aging report by pay source

C. Items 1 through 5 must be reviewed and mailed monthly.

VIII. COLLECTIONS

Collection procedures will be done monthly on all accounts. The detailed aging report by pay source will be used to accomplish the following tasks:

A. SELF PAY ACCOUNTS – ACTIVE CLIENTS

1. An account will be considered delinquent once it is 30 days old.

2. Once an account has been deemed delinquent, the reimbursement staff will issue the client a letter. A copy of the letter is filed in the client's chart to provide documentation of all collection activities.

3. Once the account becomes 60 days old, the reimbursement staff will notify the clinician/casemanager of the delinquency. The clinician/casemanager, during the next scheduled appointment, will discuss the issue and inform the client that if a payment is not received, services **could** be terminated.

4. A second letter is sent once the account becomes 60 days old. This letter explains that a previous letter was sent regarding the delinquent account and recommends payment or arrangement to be made within 30 days. A copy of the letter is filed in the client's chart.

5. If applicable, an appeal process can be initiated by the client or the clinician/casemanger if termination of services due to clinical reasons would be detrimental to the client's health or the client would pose a danger to society.

6. Once the account becomes 90 days old, a letter will be sent to the client requesting him/her to contact reimbursement to discuss his/her account. The client will also be informed that shall he/she decide not to contact the reimbursement staff, the account will be submitted for collection. A copy of the letter is filed in the client's chart.

7. Once the account becomes 120 days old, it will be deemed uncollectible, and services may be terminated due to the client's **REFUSAL** to pay (which is different from the client's **INABILITY** to pay).

8. The account is now reviewed by the Fiscal/Reimbursement Officer for final determination to transfer the balance from the active A/R and place into a Debt Set-off File. This is done so active A/R is not overstated.

9. The Fiscal/Reimbursement Officer will sign the 90-day letter to verify the transfer approval to the Debt Set Off File.

10. Should a client return for services at a later date, he/she would be required to pay the amount shown in the Debt Set Off File **prior** to services being rendered.
EXCEPTION: THE CLIENT REQUIRES EMERGENCY SERVICES!

B. SELF PAY ACCOUNT – INACTIVE ACCOUNTS

1. An account will be considered delinquent once it is 30 days old.

2. Once an account has been deemed delinquent, the reimbursement staff will issue the clients a letter. A copy of the letter is filed in the client's chart to provide documentation of all collection activities.

3. Once the account becomes 60 days old, a second letter is sent. This letter explains that a previous letter was sent regarding the delinquent account and recommends payment or arrangements to pay be made within 30 days. A copy of the letter is filed in the client's chart.

4. Once the account is 90 days old, a letter will be sent to the client requesting him/her to contact reimbursement to discuss his/her account. The client will also be informed that shall he/she decide not to contact the reimbursement staff, the account will be submitted for collection. A copy of the letter is filed in the client's chart.

5. Once the account becomes 120 days old it will be deemed un-collectible.

6. The account is now reviewed by the Fiscal/Reimbursement Officer for final determination to transfer the balance from the active A/R and place into a Debt Set Off File.

7. The Fiscal/Reimbursement Officer will sign the 90-day letter to verify the transfer approval to Debt Set Off File.

8. Should a client return for services at a later date, he/she will be required to pay the amount shown in the Debt Set Off File prior to services being rendered.
EXCEPTION: THE CLIENT REQUIRES EMERGENCY SERVICES!

C. THIRD PARTY INSURANCE ACCOUNTS – UNPAID ACCOUNTS

1. An unpaid claim is considered delinquent after 45 days of its submission.

2. A telephone call is made to the carrier to determine the status of the claim.

3. If the claim was never received, a copy of the original claim is submitted immediately.

4. If the claim has been pending for a reason, the reason is noted on the account and appropriate follow-up action will take place as required until the claim has been paid or denied.

D. THIRD PARTY INSURANCE ACCOUNTS – PAID CLAIMS

1. Those third party carriers that we are a participating provider for, i.e. Medicare, Medicaid, Blue Shield, etc., the difference between the CSB charge and allowed amount will be written off.

2. Any all applicable deductible and/or co-insurance amounts must be transferred to the client's self pay account.

3. For those third party carriers we do not have a signed contract with, i.e. Aetna, Jefferson Pilot, Connecticut General, etc., the balance from the CSB charge amount less the payment must be transferred to the client's self pay account.

E. THIRD PARTY INSURANCE ACCOUNTS – DENIED CLAIMS

1. Once a denial is received for a claim submitted, depending on the reason, the following action is taken:

   a. Denied Due To Non-Covered Service – the charge amount is transferred to the client's self pay account.

   b. Denied Due To Non-Qualified Provider – for those third party carriers that we do not have a contract with, i.e. Aetna, Jefferson Pilot, Connecticut General, etc., COMMUNITY SERVICES BOARD charges will be transferred to the client's self pay account.

   c. Denied Due To Service Limitations – the charge amount is transferred to the client's self pay account.

   d. Denied Due To No Coverage or Ineligibility – the charge amount is transferred to the client's self pay account.

   e. All other denials will require research for corrections and possible resubmission for payment.

IX. DEBT SET OFF FILE

A. Once an account is placed in the Debt Set-Off file, all billing of Client Monthly Statements will cease.

B. The Debt Set-Off file will contain the following information:

1. Client name

2. Client's account number

3. Client social security number
4. client or responsible party's address
5. Parent's name if client is a minor
6. Parent's social security number if the client is a minor
7. Amount owed
8. Payments if applicable

C. Following the monthly billing process, the Debt Set-Off client will be sent a letter of notification informing them that their account is being submitted to the Department of Taxation for a refund match if payment is not received within 30 days.

D. If no payment is received within 30 days, then a list is submitted to The Department of Taxation S.O.D.C. (Set-off Debt Collection).

E. S.O.C.D. (Set-off Debt Collection) policies are now followed.

F. Clients will remain in the bad debt/debt set-off file for five years or until payment via client of S.O.D.C. match is received, whichever occurs first.

G. Accounts are considered to be Bad Debts when all avenues of collection have been exhausted including D.S.O. and client services have been terminated at which time account will be transferred to the Bad Debt account and written off Accounts Receivable.

X. WRITE-OFF FROM DEBT SET-OFF FILE

CLIENT SELF PAY ACCOUNT

A. All accounts scheduled for write off, regardless of amount, have to be approved by the appropriate Program Director.

B. Reimbursement staff will compile a listing from the Debt Set-off File for those accounts that are five years old.

C. This list will be presented to the Reimbursement Officer for approval of the Write-offs.

XI. EMERGENCY SERVICES/CRISIS INTERVENTION BILLING

1. The Caseworker/E.S. Staff completes a Crisis Intervention Contact sheet at the time of the call or visit. This form is used to capture the service, time, and detailed demographic information needed for billing. A copy is forwarded to the Fiscal Technician for entry. The form is then filed in a completed batch.

2. A Crisis Intervention Brochure is given to the consumer at the time of the visit. The brochure provides an explanation of the service being rendered, who provided the services, and the referral source. The brochure also explains that there is a charge for the service. The perforated section of the brochure is completed by the E.S. Worker and signed by the consumer. This section is attached to the E.S. Contact Sheet, which is sent to the Fiscal Technician. The remaining piece of the brochure is given to the consumer for their information.

XII. SUBSTANCE ABUSE-DRUG & ALCOHOL FREE WORKPLACE COMPANIES

1. The SA Director establishes a contract with the company requesting the Testing and/or Assessment.

2. The SA Director sends a document stating the approved services and charges. The Reimbursement Technician assigns specific service codes, payer codes, and a client number for that company.

3. The individual tested are not “open clients”. They are they company’s employees.

4. The SA Therapist completes an Alcohol/Drug Free Workplace Service Ticket for each individual tested.

5. The ticket is forwarded to the Fiscal Technician for entry; the service ticket is filed in the company’s chart.

6. The companies will also be billed an annual Administrative Fee of $700.00. The fee is billed and due the month of the approved contract.

SUBSTANCE ABUSE – CONTRACTUAL SERVICES

1. The SA Director establishes a contract with the company requesting services for individuals.

2. The Reimbursement Technician assigns specific payer codes and service codes for the company or organization.

3. The individuals receiving services are “opened clients”.

4. The SA Therapist will complete a service ticket for the client. The therapist is to confirm the correct payer code is documented on the ticket.

5. The service ticket is forwarded to the Fiscal Technician for entry. The service ticket is filed in the completed batch.

Position: **Reimbursement Officer**
Division: **Administration**
Supervisor: **Director, Finance and Administration**

Summary

Plans, implements and oversees the agency's fee collection and reimbursement system with emphasis on maximizing fee revenue.

PRINCIPAL DUTIES AND RESPONSIBILITIES OF POSITION

1. Oversees the automated billing of consumers, and certain Third Party payers including Blue Cross Blue Shield, Medicaid and Medicare and community assistance resources and other local governmental agencies.
2. Negotiates provider contracts with insurers.
3. Processes managed care provider applications ensuring managed care standards and requirements are met, and develops procedures and provides training.
4. Trains subordinates and other clerical staff in reimbursement policies and procedures.
5. Manages delinquent accounts and collection activities.
6. Investigates and resolves consumer concerns and questions.
7. Oversees service entry, intake entry and financial entry for assigned programs.
8. Oversees agency policy and consumers ability to pay.
9. Reviews and updates fee collection and reimbursement procedures in response to law, governmental guidelines, third party insurer requirements and agency policy.
10. Identifies and coordinates utilization of available client, third party insurer and community assistance financial resources for the payment/reimbursement of agency services.
11. Coordinates and carries out resolution/disposition of delinquent accounts, including court action and state tax debt set-off.
12. Monitors the use of reimbursement-qualified clinical practices by treatment staff.
13. Develops fee revenue projections.
14. Monitors Purchase of Services contracts with outside vendors in accordance with state regulations.
15. Designs computer based fee accounting files and reports.
16. Determines and recommends appropriate fees for agency services.
17. Does related work as required.

KNOWLEDGE, SKILLS AND ABILITIES

Thorough knowledge of standard bookkeeping and accounting principles and practices. Thorough knowledge of the programs, policies and procedures of the third party insurers serving the region, including managed care plans. Thorough knowledge of the laws and governmental guidelines applicable to reimbursement and delinquent account collections procedures. Ability to plan and supervise the work of technical subordinates. Ability to interpret and analyze technical information and prepare clear and concise summaries. Ability to analyze financial data, apply statistical techniques and prepare financial reports and recommendations. Ability to establish effective working relationships with a diverse group of others.

FORMAL TRAINING AND WORK EXPERIENCE EXEMPLIFYING KSAs

Bachelor's Degree in Business Administration and some experience in fee payment collection and accounting involving third party insurance carriers, or combination of education and experience to produce the required knowledge, skills, and abilities.

PHYSICAL REQUIREMENTS

Must have the use of sensory skills in order to effectively communicate and interact with other employees and the public through the use of the telephone and personal contact as normally defined by the ability to see, read, talk, hear, handle or feel objects and controls. Incumbent performs work in an office environment. Physical capability to effectively use and operate various items of office related equipment such as, but not limited to, a personal computer, calculator, copier, and fax machine. Some walking, moving, carrying, climbing, bending, kneeling, crawling, reaching, and handling, sitting, standing, pushing, and pulling. Ability to lift boxes of up to 10 lbs.

Position: **Reimbursement Specialist**
Division: **Administration**
Supervisor: **Reimbursement Officer**

SUMMARY

Assesses the financial ability of program consumers to pay service fees and performs consumer and third party insurance billing.

ESSENTIAL FUNCTIONS/PRINCIPAL DUTIES AND RESPONSIBILITES OF POSITION

1. Conducts financial interviews and appeals; evaluates financial ability of program clients.
2. Assesses service fees and establishes payment plan.
3. Prepares and follows up on delinquent account activity.
4. Prepares and follows up consumer, insurance, and other third party billing.
5. Maintains manual and computer-based consumer account and financial information records which include the computer entry of all client related data from reimbursement and MIS forms, including financial input, payment, plan admissions, intake, discharges, SA data, updates, etc.
6. Enters corrections, data from MIS exception reports.
7. Researches and responds to consumer complaints and questions regarding billing.
8. Pursues collection activity on delinquent accounts.
9. Liaisons with treatment staff regarding client accounts to ensure accurate and timely entering of all necessary information and to research and follow up on any client account problems.
10. Does related work as required.

KNOWLEDGE, SKILLS AND ABILITIES

Good knowledge of bookkeeping practices related to the maintenance of financial records and accounts; good knowledge of the policies and procedures of the third party insurers of the population served; good knowledge of the agency's consumer fee policies; good skill in conducting financial interviews and the assessment of financial data of a diverse population; good computer skills, particularly in data entry, spreadsheet software, and word processing, ability to accurately and quickly make arithmetical calculations to prepare and maintain

financial records and accounts; ability to communicate effectively orally and in writing; ability to establish good consumer relations.

PHYSICAL REQUIREMENTS

Must have the use of sensory skills in order to effectively communicate and interact with other employees and the public through the use of the telephone and personal contact as normally defined by the ability to see, read, talk, hear, handle or feel objects and controls. Incumbent performs work in an office environment. Physical capability to effectively use and operate various items of office related equipment such as, but not limited to, a personal computer, calculator, copier, and fax machine. Some walking, moving, carrying, climbing, bending, kneeling, crawling, reaching, and handling, sitting, standing, pushing, and pulling. Ability to lift boxes of up to 10 lbs.

CSB: _____ DATE: _____

A. General and Administrative

1. Current written reimbursement policies?

_____
_____

2. Job descriptions for each reimbursement position?

_____

3. What type of continuing education and/or training is provided to reimbursement staff?

_____
_____

4. Are employees given training on client confidentiality and release of information?

_____
_____

5. Are copies of the following references or manuals maintained in the CSB administrative offices and available as necessary to the reimbursement staff:

		YES	NO
a.	Code of Virginia	___	___
b.	DMHMRSAS Reimbursement Manual	___	___
c.	Set-Off Debt Collections Procedures	___	___
d.	Medicare Manual	___	___
e.	Medicaid Manual	___	___
f.	Blue Cross/Blue Shield Manual	___	___
g.	Champus Manual	___	___
h.	Local (city/county) policies/procedures	___	___

B. Intake Procedures

1. Are clients notified of financial responsibility prior to the initial intake?

_____
_____

2. When are financial interviews conducted?

_____
_____

3. In what setting are financial interviews conducted?

_____
_____

4. Who conducts the financial interview?

_____
_____

5. Is the client required to sign fee agreements?

_____
_____

6. When is third party coverage verified?

_____
_____

C. Ability to Pay

1. Explain what type of fee assessment methodology is used by your CSB.

_____
_____

2. Is income verified before fees are assessed? If not, explain why.

---

3. Who is involved in fee setting?

---

4. What is your CSB's minimum fee? If it is zero, explain why.

_____
_____

5. How often are client fee assessments updated?

_____
_____

D. Client Financial Records

1. Where are client financial records maintained?

---

2. Does the client financial record contain the following:

a.	Financial questionnaire	___	___
b.	Copies of third party payor card(s)	___	___
c.	Signed payment agreement	___	___

d.	Assignment of benefits and release forms to bill third party payors	___	___
e.	Income verification	___	___
f.	Insurance verification and/or pre-authorization	___	___
g.	Correspondence (i.e., third party, clients, etc.)	___	___

3. Are clinical records available to reimbursement staff?

_____
_____

E. Third Party Billing

1. Do you operate a parent-infant program? If so, is it certified?

_____
_____

2. What third party carriers do you bill?

CARRIER	HOW OFTEN
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

3. How often do you follow-up on unpaid claims?

_____
_____

4. Are payments demanded of third party payors if payment is sent to the subscriber in error?

_____
_____

F. Accounts Receivable

1. Are statements regularly sent out:

a. For all accounts? If no, designate those, which are not sent out.

_____

b. At least monthly? If no, designate frequency.

_____

c. By whom?

_____

d. By a person independent of ledger posting?

_____

e. By a person with no access to cash?

_____

2. Are aging schedules:

a. Prepared monthly? If no, designate frequency.

_____

b. By whom are the schedules reviewed?

_____

G. Bad Debt Write-offs

1. What are the CSB's written credit and collection policies and procedures?

_____
_____

2. When are accounts written off?

_____
_____

3. Who determines what accounts are to be written off and on what basis is this decision made?

_____
_____

4. Who approves write-offs and on what basis is the approval made?

_____
_____

H. Cash Receipts – Mail Receipts

1. Mail is opened by:

Name: _____
Title: _____

a. Does this person have any duties related to:

1. Accounts receivable bookkeeping ___ ___

2. Credit and collections ___ ___
If yes, explain:

_____
_____

2. Are checks restrictively endorsed immediately upon receipt by the person opening the mail? ___ ___
If not, then by whom and when.

_____
_____

3. Is a record of the money and checks received prepared by the person opening the mail? ___ ___
If not, by whom?

Name: _____
Title: _____

a. Is this record verified with the deposit? ___ ___

If yes, by whom.

Name: _____
Title: _____

I. Cash Receipts - Counter Receipts

1. If manual receipts are used:

a. Are receipts pre-numbered? ___ ___

b. Numerical sequence is checked by whom: ___ ___

Name: _____
Title: _____

c. How are unused receipt books safeguarded?

_____
_____

2. Are checks restrictively endorsed immediately upon receipt? ____ ____

3. Receipts are handled by the following individuals up to and including the deposit:

Name: _____
Title: _____

Name: _____
Title: _____

Name: _____
Title: _____

4. Who prepares the deposit?

Name: _____
Title: _____

a. Does this person have any other cash duties? ___ ___
If so, what duties:
_____

5. Who takes the deposit to the bank?

Name: _____
Title: _____

a. Does this person have any other cash or accounts receivable duties? ___ ___
If so, what duties?
_____

b. Are each day's receipts deposited intact on that day? If not, please explain ____ _____
_____
_____

6. Where are receipts that are not immediately deposited maintained?
_____
_____

J. <u>Representative Payee</u>

1. Are Board employees Representative Payee for clients? ____ ____
If so, what staff positions?

---

2. Are there written policy and procedures for representative payees? ____ _____

3. Are there individual bank accounts established for each client with a representative payee? ____ _____

4. Are client income checks directly deposited electronically into the bank account? ____ _____
If no, how are client income checks deposited into the client's bank account.

---

5. Are client bank accounts reconciled routinely? _____ _____
If yes, how often and by whom?

---

6. Are year-end expenditure reports created and reconciled? _____ _____

K. Information Systems

1. How frequently is the automated accounts receivable system backed up?

   _____

2. Is the data stored off site? _____ _____
   If yes, where?
   _____

Executive Director: _____

Date _____

Fiscal Director: _____

Date _____